

Kansas Medical Assistance Program Prior Authorization Request Form for Non-Preferred Drugs

If you would like to prescribe a Preferred Drug,
Please do so in the space provided and
FAX form back to the dispensing pharmacy.

Otherwise, continue with the Prior Authorization
process by completing the rest of this form &
FAX completed form to the Prior Authorization Unit
@ 1-800-913-2229 (274-5956 Topeka)

Rx

Physician signature

Date

Growth Hormone *Clinical Prior Authorization is still required for all Growth Hormones

Preferred Drug Covered

Somatropin

Tev-Tropin®

Non-preferred Prior Authorization Required

Somatropin

Genotropin®

Humatrope®

** Includes all alternative
delivery systems and
formulations

Norditropin®

Nutropin®

Saizen®

**** Indicates REQUIRED information**

****CONSUMER NAME:** _____

****Medicaid Number:** _____

****PHARMACY NAME:** _____

****Medicaid Number:** _____

****Phone Number:** _____

****Fax Number:** _____

****NDC:** _____

****PRESCRIBING PHYSICIAN NAME:** _____

****Medicaid Number:** _____

****Phone Number:** _____

****Fax Number:** _____

☐

**** Absence of appropriate indication of the drug.** Please specify: _____

****Prescribing Physician's signature:** _____ **Date:** _____

If the pharmacy provider has started a Prior Authorization request and this information is not received within 15 working days, the PA request will be denied. **For questions related to Prior Authorization, contact 800-285-4978, option #3 or 274-5499, in Topeka.** General support is provided at 800-933-6593. For questions related to pharmacy issues, contact the Pharmacy Help Desk toll-free at 866-405-5200.

Kansas Medical Assistance Programs



Provider Line: 1-800-933-6593
Consumer Line: 1-800-766-9012

P.O. Box 3571, Topeka KS 66601-3571
Prior Authorization: 1-800-285-4978 or 785-274-5499
Prior Authorization Fax Lines: 1-800-913-2229 or 785-274-5956

CHILDREN GROWTH HORMONE RENEWAL REQUEST FORM

Please note: If non-preferred drug is ordered, please include PDL (Preferred Drug List) form in addition to this request form.

Consumer Name: _____ Date: ____/____/____

Consumer ID#: _____ Date Of Birth: ____/____/____

Drug Requested: _____ NDC: _____

Pharmacy Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Pediatric Endocrinologist Name: _____ Provider Medicaid ID#: _____

Phone Number: (____) _____ Fax Number: (____) _____

Provider Contact Person: _____ Phone Number: (____) _____

1. Please include History & Physical, growth curve, height velocity and clinical notes within 6 months of request.

2. Growth rate over 6 month period (please include 3 measurements in centimeters).

Date ____/____/____ Height in centimeters _____

Date ____/____/____ Height in centimeters _____

Date ____/____/____ Height in centimeters _____

3. Is consumer compliant with Growth Hormone therapy? _____

4. Radiological evidence of open epiphyseal growth plates for boys >16yr age and girls >15 yr age.

Signature of Physician or Designee: _____

Completed form should be faxed to 1-800-913-2229.
This form will be returned unprocessed if it is not completed in its entirety.
Initial prior authorization is for 6 months or at SRS Program Manager's discretion.